		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039339

Facility Name: Jerseyville Nursing and Rehabilitation Center

Address: 1001 South State Street (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: (618) 498-6496 **Fax #** (618) 498-7435

IDPA ID Number: 37-1323741

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, Illinois 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		10,625	4,397	15,022	8
9	SNF/PED					9
10	ICF	18,450			18,450	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,450	10,625	4,397	33,472	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.80%

D. How many bed-hold days during this year were paid by Public Aid?
52 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 04/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 21 and days of care provided 4,397

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	167,261	17,226	4,395	188,882		188,882		188,882			1
2	Food Purchase		170,240		170,240		170,240	(373)	169,867			2
3	Housekeeping	84,340	13,303		97,643		97,643		97,643			3
4	Laundry	73,169	16,490		89,659		89,659		89,659			4
5	Heat and Other Utilities			99,744	99,744		99,744	702	100,446			5
6	Maintenance	49,090	6,470	22,817	78,377		78,377	785	79,162			6
7	Other (specify):* Waste Removal			7,120	7,120		7,120		7,120			7
8	**TOTAL General Services**	373,860	223,729	134,076	731,665		731,665	1,114	732,779			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,056,444	84,693	18,803	1,159,940	(1,829)	1,158,111	(291)	1,157,820			10
10a	Therapy	36,007	1,246	303,834	341,087		341,087	(45,206)	295,881			10a
11	Activities	32,920	2,715	1,386	37,021	566	37,587		37,587			11
12	Social Services	40,532	183	1,386	42,101		42,101		42,101			12
13	Nurse Aide Training					3,421	3,421		3,421			13
14	Program Transportation		1,952		1,952		1,952		1,952			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,165,903	90,789	335,009	1,591,701	2,158	1,593,859	(45,497)	1,548,362			16
	C. General Administration											
17	Administrative	60,011	2,901	200,722	263,634	(1,278)	262,356	(45,650)	216,706			17
18	Directors Fees											18
19	Professional Services			59,764	59,764		59,764	11,802	71,566			19
20	Dues, Fees, Subscriptions & Promotions			36,151	36,151	(1,461)	34,690	(18,440)	16,250			20
21	Clerical & General Office Expenses	51,773	13,689	39,802	105,264		105,264	25,485	130,749			21
22	Employee Benefits & Payroll Taxes			217,694	217,694	169	217,863	13,847	231,710			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,376	6,376	(40)	6,336	578	6,914			24
25	Other Admin. Staff Transportation							3,942	3,942			25
26	Insurance-Prop.Liab.Malpractice			56,846	56,846		56,846	3,585	60,431			26
27	Other (specify):*											27
28	**TOTAL General Administration**	111,784	16,590	617,355	745,729	(2,610)	743,119	(4,851)	738,268			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,651,547	331,108	1,086,440	3,069,095	(452)	3,068,643	(49,234)	3,019,409			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center #0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			177,500	177,500		177,500	6,522	184,022			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			312,641	312,641		312,641	(9,659)	302,982			32
33	Real Estate Taxes			44,516	44,516		44,516	730	45,246			33
34	Rent-Facility & Grounds							5,471	5,471			34
35	Rent-Equipment & Vehicles			5,056	5,056		5,056	1,013	6,069			35
36	Other (specify):* **Mortgage Ins.**			18,383	18,383		18,383		18,383			36
37	**TOTAL Ownership**			558,096	558,096		558,096	4,077	562,173			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,899	10,846	119,745		119,745		119,745			39
40	Barber and Beauty Shops					452	452		452			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		108,899	66,143	175,042	452	175,494		175,494			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,651,547	440,007	1,710,679	3,802,233		3,802,233	(45,157)	3,757,076			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(94)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,309)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(895)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,337)	24		19
20	Contributions	(4,125)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,505)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,791)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,056)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(21,101)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (21,101)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (45,157)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops	x		452	17	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 452		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Jerseyville Nursing and Rehabilitation Center

ID# 0039339

Report Period Beginning: 1/1/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Expense	$ (279)	2	1
2	Offset Miscellaneous Income Against Expense	(291)	10	2
3	Eliminate PAC & Lobbying Dues	(3,303)	20	3
4	Eliminate 2003 IDPH license paid in 2002	(200)	20	4
5	Eliminate Chamber of Commerce dues	(175)	20	5
6	Eliminate non-care related seminars	(1,425)	24	6
7	Eliminate additional meals and entertainment	(118)	17	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,791)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(373)	0	0	0	0	0	0	0	0	0	0	(373)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	702	0	0	0	0	0	0	0	0	0	702	5
6	Maintenance	0	785	0	0	0	0	0	0	0	0	0	785	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(373)	1,487	0	0	0	0	0	0	0	0	0	1,114	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(291)	0	0	0	0	0	0	0	0	0	0	(291)	10
10a	Therapy	0	0	(45,206)	0	0	0	0	0	0	0	0	(45,206)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(291)	0	(45,206)	0	0	0	0	0	0	0	0	(45,497)	16
	C. General Administration													
17	Administrative	(118)	155,190	(200,722)	0	0	0	0	0	0	0	0	(45,650)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	848	10,954	0	0	0	0	0	0	0	0	11,802	19
20	Fees, Subscriptions & Promotions	(19,203)	763	0	0	0	0	0	0	0	0	0	(18,440)	20
21	Clerical & General Office Expenses	0	25,485	0	0	0	0	0	0	0	0	0	25,485	21
22	Employee Benefits & Payroll Taxes	0	13,847	0	0	0	0	0	0	0	0	0	13,847	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,762)	3,340	0	0	0	0	0	0	0	0	0	578	24
25	Other Admin. Staff Transportation	0	3,942	0	0	0	0	0	0	0	0	0	3,942	25
26	Insurance-Prop.Liab.Malpractice	0	3,585	0	0	0	0	0	0	0	0	0	3,585	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,083)	207,000	(189,768)	0	0	0	0	0	0	0	0	(4,851)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,747)	208,487	(234,974)	0	0	0	0	0	0	0	0	(49,234)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	6,522	0	0	0	0	0	0	0	0	0	6,522	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,309)	92	(8,442)	0	0	0	0	0	0	0	0	(9,659)	32
33	Real Estate Taxes	0	730	0	0	0	0	0	0	0	0	0	730	33
34	Rent-Facility & Grounds	0	0	5,471	0	0	0	0	0	0	0	0	5,471	34
35	Rent-Equipment & Vehicles	0	0	1,013	0	0	0	0	0	0	0	0	1,013	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,309)	7,344	(1,958)	0	0	0	0	0	0	0	0	4,077	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,056)	215,831	(236,932)	0	0	0	0	0	0	0	0	(45,157)	45

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 5,471	$ 5,471	15
16	V	35	See Schedule VIII		Wellington Management Co.	60.00%	1,013	1,013	16
17	V	17	Management Fees	144,520	Wellington Management Co.	60.00%		(144,520)	17
18	V	17	Management Fees	56,202	Health Care Financial, LLC	40.00%		(56,202)	18
19	V	19	Professional Services	41,701	C.J. Schlosser & Company, LLC	40.00%	52,655	10,954	19
20	V	10a	Therapy Services	303,834	NW Rehab, LLC	100.00%	258,628	(45,206)	20
21	V	32	Interest	8,442	John H. Rothert	60.00%		(8,442)	21
22	V	19	Professional Services	6,900	Montgomery Nursing & Rehabilitation Center, Inc.	0.00%	6,900		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 561,599			$ 324,667	$ * (236,932)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Montgomery Nursing & Rehabilitation Center	Hillsboro, IL	Wellington Mgmt Co	Chesterfield, MO	Management Co
David L. Kamler	10.00	Westwood Hills Healthcare Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co
J. Terry Dooling	10.00			C.J. Schlosser & Co.	Alton, IL	Public Accountants
R.J. Tolliver	10.00			NW Rehab, L.L.C.	Alton, IL	Therapy Co.
Jack A. Yaeger	10.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 702	$ 702	1
2	V	6	See Schedule VIII		Wellington Management Co.	60.00%	785	785	2
3	V	17	See Schedule VIII		Wellington Management Co.	60.00%	155,190	155,190	3
4	V	19	See Schedule VIII		Wellington Management Co.	60.00%	848	848	4
5	V	20	See Schedule VIII		Wellington Management Co.	60.00%	763	763	5
6	V	21	See Schedule VIII		Wellington Management Co.	60.00%	25,485	25,485	6
7	V	22	See Schedule VIII		Wellington Management Co.	60.00%	13,847	13,847	7
8	V	24	See Schedule VIII		Wellington Management Co.	60.00%	3,340	3,340	8
9	V	25	See Schedule VIII		Wellington Management Co.	60.00%	3,942	3,942	9
10	V	26	See Schedule VIII		Wellington Management Co.	60.00%	3,585	3,585	10
11	V	30	See Schedule VIII		Wellington Management Co.	60.00%	6,522	6,522	11
12	V	32	See Schedule VIII		Wellington Management Co.	60.00%	92	92	12
13	V	33	See Schedule VIII		Wellington Management Co.	60.00%	730	730	13
14	Total			$			$ 215,831	$ * 215,831	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	John H. Rothert	President	Administrative	60.00	283,985	12.58	31.00	Salary	$ 130,282	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 130,282		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Wellington Management Company
Street Address: 750 Spirit 40 Park Drive
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (636-537-8447
Fax Number: (636-537-8446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	11,459,967	4	$ 2,231	$	3,604,024	$ 702	1
2	6	Maintenance	Accumulated Costs	11,459,967	4	2,496		3,604,024	785	2
3	17	Administrative	Accumulated Costs	11,459,967	4	493,470	493,470	3,604,024	155,190	3
4	19	Professional Services	Accumulated Costs	11,459,967	4	2,698		3,604,024	848	4
5	20	Dues,Fees, Subscriptions & Promo	Accumulated Costs	11,459,967	4	2,425		3,604,024	763	5
6	21	Clerical & General Office Exp.	Accumulated Costs	11,459,967	4	81,036	43,131	3,604,024	25,485	6
7	22	Employee Benefits & PR Taxes	Accumulated Costs	11,459,967	4	44,032		3,604,024	13,847	7
8	24	Travel and Seminar	Accumulated Costs	11,459,967	4	10,621		3,604,024	3,340	8
9	25	Other Admin. Staff Transport	Accumulated Costs	11,459,967	4	12,535		3,604,024	3,942	9
10	26	Insurance- Prop.,Liab.,Malprac.	Accumulated Costs	11,459,967	4	11,398		3,604,024	3,585	10
11	30	Depreciation	Accumulated Costs	11,459,967	4	20,737		3,604,024	6,522	11
12	32	Interest	Accumulated Costs	11,459,967	4	294		3,604,024	92	12
13	33	Real Estate Taxes	Accumulated Costs	11,459,967	4	2,321		3,604,024	730	13
14	34	Rent - Facility & Grounds	Accumulated Costs	11,459,967	4	17,395		3,604,024	5,471	14
15	35	Rent - Equipment & Vehicles	Accumulated Costs	11,459,967	4	3,221		3,604,024	1,013	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 706,910	$ 536,601		$ 222,315	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mortgage		X	Mortgage Loan	$26,697.36	4/17/00	$ 3,720,700	$ 3,664,381	05/01/2035	8.1000	$ 297,817	1
2												2
3	Chrysler Financial		X	Vehicle Loan	$658.80	9/30/00	23,391	6,561	09/30/2003	0.9000	86	3
4									Loan Cost Amortization		5,178	4
5												5
	Working Capital											
6	First National Bank		X	Line of Credit	N/A	01/04/02	100,000	1	01/04/03	5.7500	1,118	6
7									Home Office Allocation		92	7
8												8
9	TOTAL Facility Related				$27,356.16		$ 3,844,091	$ 3,670,943			$ 304,291	9
	B. Non-Facility Related*											
10									Interest Income		(1,309)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,309)	14
15	TOTALS (line 9+line14)						$ 3,844,091	$ 3,670,943			$ 302,982	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 18,383 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	24,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	27,516	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,516	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	41,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	44,516	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	23,276	8
	1998	23,681	9
	1999	23,468	10
	2000	23,113	11
	2001	27,516	12

Line 2: 2001 Taxes Paid

Line 4: Accrual is calculated from most recent assessments received.

Line 7: $44,516 + $730 (Home Office R.E. Tax Allocation) = $45,246 Total R.E. Taxes - Schedule V, Col. 8.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Nursing and Rehabilitation Center COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039339

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-875-004-00	Outlots 59, 62, 63 & 64 S Pt Outlot 62	$ 24,741.48	$ 24,741.48
2.	04-208-017-00	S28 T8 R11 Unplatted Parcels	$	$
3.		S & W PT SE 1/4 NE 1/4 Less E PT	$ 1,387.43	$ 1,387.43
4.		Less .10 ACS for HWY	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,128.91	$ 26,128.91

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,948 B. General Construction Type: Exterior Brick & Siding Frame Steel and Brick Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	158,994	1994	$ 71,664	1
2					2
3	TOTALS	158,994		$ 71,664	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 1,180,668	$ 47,227	25	$ 47,227	$	$ 413,234	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot			1994	26,304	2,469	5-10	2,469		22,638	9
10	Exterior Remodeling			1994	10,000	667	15	667		5,723	10
11	Flooring			1994	29,698	2,970	10	2,970		24,922	11
12	Electrical			1994	11,690	584	20	584		4,818	12
13	Air Conditioning			1994	25,830	2,583	10	2,583		21,525	13
14	Interior Remodeling			1994	40,265	1,359	5-20	1,359		30,894	14
15	Shed			1994	3,267	327	10	327		2,832	15
16	Nurses' Station			1994	6,055	303	20	303		2,599	16
17	Home Office Wallpapering/Flooring			1994	4,972		5			4,972	17
18	Painting			1995	7,392		5			7,392	18
19	Electrical			1995	3,382	338	10	338		2,649	19
20	Call Lights			1995	1,564	104	15	104		756	20
21	Storage Building			1996	3,500	350	10	350		2,100	21
22	2 Boilers			1996	7,400	370	20	370		2,559	22
23	Roof Repair & Drains Installed			1996	3,619	362	10	362		2,443	23
24	Ceiling Tile & End Caps			1996	3,506	292	12	292		1,802	24
25	Storage Building			1997	3,356	336	10	336		1,986	25
26	Alarm System			1997	1,750	175	10	175		1,035	26
27	Wallcovering			1997	6,355	708	5-10	708		4,977	27
28	Ceiling Tile			1997	1,485	124	12	124		681	28
29	3 Windows & Sills & 1 Door Replaced			1997	4,108	274	15	274		1,461	29
30	Baseboards Remodeled			1997	1,166	116	10	116		622	30
31	Air Conditioner Unit			1997	2,185	219	10	219		1,196	31
32	Concrete Pation & Sidewalk			1997	1,842	123	15	123		655	32
33	Rock			1997	502	17	5	17		502	33
34	Landscaping			1997	1,075	108	10	108		609	34
35	Roofing			1998	2,592	259	10	259		1,274	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Shower Room Remodeled	1998	$ 1,437	$ 144	10	$ 144	$	$ 707	37
38	Baseboard Remodeling	1998	1,919	192	10	192		887	38
39	Air Conditioning Units & Ducts	1998	13,420	1,280	10-20	1,280		5,738	39
40	Wallcoverings	1998	1,495	150	10	150		610	40
41	4 Air Conditioning Units	1999	2,840	284	10	284		970	41
42	Roofing	1999	35,386	3,539	10	3,539		13,270	42
43	Home Office Wallpapering	1999	836		5	167	167	641	43
44	3 Air Conditioning Units	2000	2,118	212	10	212		512	44
45	Wallcoverings	2000	2,231	446	5	446		1,078	45
46	Chair Railings	2000	6,267	418	15	418		867	46
47	Cove Base	2000	1,797	180	10	180		360	47
48	Constr. Of 400 Wing-Design, Architecture & Engineering	2001	67,723	2,709	25	2,709		4,063	48
49	Constr. Of 400 Wing-Contractor Costs	2001	943,708	37,748	25	37,748		56,622	49
50	Constr. Of 400 Wing-Drawings, Surety Bond & Misc.	2001	11,223	449	25	449		673	50
51	Cosntr. Of 400 Wing-Interest & Mortgage Ins. Premiums	2001	89,316	3,573	25	3,573		5,359	51
52	400 Wing Nurse Call System	2001	10,104	674	15	674		1,010	52
53	400 Wing Cable TV System Cabling	2001	1,962	196	10	196		294	53
54	400 Wing Fire Alarm System	2001	14,696	980	15	980		1,470	54
55	400 Wing Telecommunication System	2001	4,025	402	10	402		604	55
56	400 Wing Door Monitor System	2001	2,640	264	10	264		396	56
57	400 Wing TV Wall Mounts	2001	6,030	603	10	603		905	57
58	400 Wing Signage	2001	1,161	232	5	232		348	58
59	400 Wing Hand Rails & Wall Guards	2001	2,319	155	15	155		232	59
60	400 Wing Chair Rails, Wallpaper & Border	2001	4,208	842	5	842		1,262	60
61	400 Wing Door Guards	2001	607	121	5	121		182	61
62	400 Wing Cubicle Tracks & Curtains & Window Treatments	2001	15,188	1,962	5-20	1,962		2,943	62
63	Landscaping, Shrubs & Trees	2001	11,744	1,171	10	1,171		2,055	63
64	Fencing	2001	4,200	525	8	525		875	64
65	Wallpaper & Border-Existing Facility	2001	55,671	11,134	5	11,134		21,566	65
66	Storage Building	2001	3,268	327	10	327		599	66
67	Carpet-Administrative Offices	2001	2,687	537	5	537		985	67
68	Nurse Call System Services-Existing Facility	2001	3,700	247	15	247		391	68
69	Alarm System Services-Existing Facility	2001	3,903	260	15	260		520	69
70	TOTAL (lines 4 thru 69)		$ 2,725,357	$ 134,720		$ 134,887	$ 167	$ 697,850	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,725,357	$ 134,720		$ 134,887	$ 167	$ 697,850	1
2	Replacement Signage-Existing Facility	2001	3,656	731	5	731		1,341	2
3	Door Guards-Existing Facility	2001	1,979	396	5	396		627	3
4	Vinyl Flooring & Cove Base 400 Wing	2001	11,615	1,162	10	1,162		1,742	4
5	25 Overbed Lights	2001	1,625	163	10	163		230	5
6	Painting Door Frames	2001	8,932	1,786	5	1,786		3,126	6
7	2P 50 Amp Disconnect	2001	955	48	20	48		68	7
8	Mini Blinds, Valances & Rods	2001	14,744	2,949	5	2,949		3,440	8
9	Asphalt Paving of Parking Lot	2001	14,193	1,419	10	1,419		2,365	9
10	A/C Units	2001	3,424	342	10	342		529	10
11	Overbed Lights	2002	3,055	258	10	258		258	11
12	Cubicle Curtains	2002	6,155	940	5	940		940	12
13	2 A/C Units	2002	1,398	93	10	93		93	13
14	Security Camera System	2002	1,010	101	5	101		101	14
15	Fire Doors	2002	1,543	51	15	51		51	15
16	Roofing-North Entrance	2002	1,680	28	10	28		28	16
17	Wall Guard & End Caps	2002	1,497	17	15	17		17	17
18	Downpayment on Door Canopy	2002	1,900						18
19	Landscaping	2002	1,729	43	10	43		43	19
20	Home Office Light Fixtures	2002	303		10	28	28	28	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,806,750	$ 145,247		$ 145,442	$ 195	$ 712,877	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 251,431	$ 22,382	$ 24,604	$ 2,222	5-20	$ 82,867	71
72	Current Year Purchases	30,229	2,662	2,897	235	5-20	2,897	72
73	Fully Depreciated Assets	265,667	980	1,095	115	5-7	265,667	73
74								74
75	TOTALS	$ 547,327	$ 26,024	$ 28,596	$ 2,572		$ 351,431	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2000 Dodge Grand Caravan	2000	$ 24,916	$ 6,229	$ 6,229	$	4	$ 14,015	76
77	Home Office Admin	2000 Taurus	2000	7,490		1,873	1,873	4	4,369	77
78	Home Office Admin	1997 Jaguar-Disposed 2002	2000			1,794	1,794	4		78
79	Home Office Admin	1992 Minivan-Disposed 2002	2000			88	88	4		79
80	TOTALS			$ 32,406	$ 6,229	$ 9,984	$ 3,755		$ 18,384	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,458,147	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 177,500	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,022	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,522	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,082,692	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ 5,056 Description: Copier $4,587, Postage Machine $469
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			121		121
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		1,920		1,920
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			1,380		1,380
9	TOTALS		$	$ 3,421	$	$ 3,421
10	SUM OF line 9, col. 1 and 2	(e)	$ 3,421			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	25

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	4484	hrs	$ 114,584		$	$ 315	4,484	$ 114,899	1
2	Licensed Speech and Language Development Therapist	10a,8	1548	hrs	49,212				1,548	49,212	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,8	3541	hrs	94,832			931	3,541	95,763	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				108,899		108,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	X-Rays	39,3					1,248			1,248	13
	Other (specify): Lab Fees	39,3					9,598			9,598	
14	TOTAL				$ 258,628		$ 10,846	$ 110,145	9,573	$ 379,619	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 129,697	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,000)	709,304		3
4	Supply Inventory (priced at Cost)	8,737		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,745		6
7	Other Prepaid Expenses	10,233		7
8	Accounts Receivable (owners or related parties)	85,216		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 964,932	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,300		12
13	Land	133,252		13
14	Buildings, at Historical Cost	2,739,052		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	553,066		16
17	Accumulated Depreciation (book methods)	(1,059,922)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	106,511		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	167,188		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,669,447	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,634,379	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 362,968	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,349		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,322		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Stockholder	85,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 614,639	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	29,960		39
40	Mortgage Payable	3,664,381		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,694,341	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,308,980	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (674,601)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,634,379	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (855,696)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (855,696)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	181,095	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 181,095	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (674,601)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,946,940	1
2	Discounts and Allowances for all Levels	(589,422)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,357,518	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	18,213	5
6	Therapy	471,109	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 489,322	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,122	13
14	Non-Patient Meals	94	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	110,801	19
20	Radiology and X-Ray	3,364	20
21	Other Medical Services	17,221	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 132,602	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,309	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,309	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	819	28
28a	Miscellaneous Income	1,758	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,577	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,983,328	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	731,665	31
32	Health Care	1,591,701	32
33	General Administration	745,729	33
	B. Capital Expense		
34	Ownership	558,096	34
	C. Ancillary Expense		
35	Special Cost Centers	119,745	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,802,233	40
41	**Income before Income Taxes (line 30 minus line 40)****	181,095	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 181,095	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Filed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,997	2,124	$ 47,462	$ 22.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,789	11,507	191,294	16.62	3
4	Licensed Practical Nurses	15,175	16,528	225,641	13.65	4
5	Nurse Aides & Orderlies	64,629	67,546	570,907	8.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,383	3,914	36,007	9.20	8
9	Activity Director					9
10	Activity Assistants	4,090	4,339	32,920	7.59	10
11	Social Service Workers	3,985	4,064	40,532	9.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,795	25,038	167,261	6.68	15
16	Dishwashers					16
17	Maintenance Workers	4,538	4,832	49,090	10.16	17
18	Housekeepers	12,571	12,956	84,340	6.51	18
19	Laundry	10,452	10,983	73,169	6.66	19
20	Administrator	2,143	2,214	60,011	27.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,013	4,534	51,773	11.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,810	2,075	21,140	10.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,370	172,654	$ 1,651,547 *	$ 9.57	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	147	$ 4,395	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	24	1,080	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,500	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,386	11,3	44
45	Social Service Consultant	22	1,386	12,3	45
46	Other(specify) Nurse Consultant	N/A	16,223	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	215	$ 35,570		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	Section N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terrie Weible	Administrator	0.00	$ 60,011
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,011

B. Administrative - Other

Description	Amount
Wellington Management Company - Management Fees	$ 144,520
Health Care Financial, L.L.C. - Management Fees	56,202
TOTAL (agree to Schedule V, line 17, col. 3)	$ 200,722
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, L.L.C.	Accounting Fees	$ 41,701
Hughes & Associates	Audit Fees	5,169
Ted Frapolli	Legal Fees	4,539
Sandberg, Phoenix & von Gontard	Legal Fees	82
Newman, Goldfarb, et al	Legal Fees	56
Scott W. Schultz	Legal Fees	926
McMahon, Berger, Hanna, et al	Legal Fees	391
Montgomery Nursing & Rehab	Medicare Billing Consult	6,900
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,764

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,213
Unemployment Compensation Insurance	13,876
FICA Taxes	121,410
Employee Health Insurance	18,744
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Disability Insurance	518
Employee Dental Insurance	292
Staff Relations	6,641
Employee Physicals	169
Home Office Employee Benefits	13,847
TOTAL (agree to Schedule V, line 22, col.8)	$ 231,710

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	9,252
Health Care Worker Background Check	
(Indicate # of checks performed 28)	336
Licenses & Fees	512
Dues & Subscriptions	2,245
Service Charges	349
IHCA Dues	2,593
Home Office Dues & Subs	763
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,250

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,237
Seminar Expense	1,337
Home Office Travel & Seminar	3,340
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,914

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association-$2,593**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **94**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **17%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Hughes & Associates** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2002

DESCRIPTION	LINE #	INCREASE (DECREASE)
ADMINISTRATIVE	17	(1,278)
BARBER & BEAUTY SHOPS	40	452
ACTIVITIES	11	566
EMPLOYEE BENEFITS	22	169
NURSING & MEDICAL RECORDS	10	91
To reclass various expenses to proper lines		
NURSE AIDE TRAINING	13	1,461
DUES, FEES SUBSCRIPTIONS & PROMOS	20	(1,461)
To reclass CNA test fees to proper lines		
NURSE AIDE TRAINING	13	40
TRAVEL & SEMINAR	24	(40)
To reclass CNA books to proper lines		
NURSE AIDE TRAINING	13	1,920
NURSING & MEDICAL RECORDS	10	(1,920)
To relcass CNA trainer wages		

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2002

EMPLOYEE FLU SHOTS	240
PROMO ADS REIMBURSEMENTS	423
EMPLOYEE NAMETAGS	14
MEDICAL SUPPLIES REIMBURSEMENTS	51
DIETARY FOOD REIMBURSEMENTS	279
COPIES OF MED RECORDS	173
OTHER MISCELLANEOUS INCOME	578
	1,758

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2002

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST
Carolyn Martin	MDS Coordinator	10/2/2002	Springfield, IL	MDS Basics	IHCA	90
Terrie Skaggs	Administrator	6/7/2002	St. Louis, MO	Psychiatric Disorders: Identification & Treatment	MO. League for Nursing	105
Terrie Skaggs	Administrator	6/21/2002	St. Peters, MO	Staffing: Strategies & Solutions for Long Term Care	MO. League for Nursing	105
Terrie Skaggs	Administrator	2/19/2002	Mt. Vernon, IL	IOC Provider Training	IHCA	100
Donna Whitehead	Social Services	2/12/2002	Springfield, IL	The ABC's of IOC's for Social Service	Outcome Services of Illinois	65
Cindy Bloodworth	Activities	2/12/2002	Springfield, IL	The ABC's of IOC's for Social Service	Outcome Services of Illinois	65
Carolyn Martin	MDS Coordinator		Springfield, IL	MDS Basics	IHCA	115
Various	Various	9/2002	Springfield, IL	IHCA Convention	IHCA	545
Ann Amos	Director of Operations	6/6/2002	St. Louis, MO	Writing Resident Care Plans	Medical & Professional Seminars	45
Ann Amos	Director of Operations	7/2002	Springfield, IL		IHCA	30
						1265
					Training Manual	72
					Home Office Travel & Seminar	3340
					Other Travel <$250 Each	2237
					Total Travel & Seminar, Line 24	6914